



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5301 S MCCOLL ROAD
EDINBURG TX 78539

Carrier's Austin Representative Box
19

Respondent Name

WC SOLUTIONS

MFDR Date Received

APRIL 9, 2007

MFDR Tracking Number

M4-07-4952-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not include a position summary with their dispute.

Amount in Dispute: \$8,191.09

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Due to the service, Doctors Hospital of Renaissance failed to obtain the necessary preauthorization for the outpatient procedure performed."

Response Submitted by: Edwards Claims Administration, 1002 Marble Heights Drive, Marble Falls, TX 78654

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
April 27, 2006	Outpatient Hospital Services	\$8,191.09	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W11 – Entitlement to benefits. Not finally adjudicated.
- 18 – Duplicate claim/service.
- This procedure on this date was previously reviewed
- 62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.

Issues

1. Has the extent of injury issue been resolved?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier submitted a PLN-11 for date of injury February 10, 2006 stating, "Carrier disputes claim in its entirety. Claimant did not sustain a compensable injury in the course and scope of his employment of 02/10/2006. Carrier's investigation into claimant's reported incident resulted in claimant not being deemed a credible witness. Claimant has not provided any credible evidence that supports his allegation that his right knee injury was caused by his employment with Mission CISD." A Benefit Review Conference was held on December 12, 2006 to mediate resolution of the disputed issues regarding whether the claimant sustained a compensable injury on February 10, 2006, whether the claimant's compensable injury on February 10, 2006 extends to include a lateral meniscal tear of the right knee and whether the claimant had disability resulting from an injury sustained on February 10, 2006, and, if so, for what period(s), however the parties were unable to reach an agreement. A Contested Case Hearing was held on February 1, 2007 that found that the injured employee did sustain a compensable injury on February 10, 2006; the claimant's sustained compensable injury on February 10, 2006 includes a lateral meniscal tear of the right knee and that claimant had disability from April 27, 2006 through May 14, 2006, and for no other period. The provider billed with the following ICD-9 codes on the CMS 1500 forms: 717.42 (Derangement Anterior Lateral Meniscus); 401.9 (Hypertension, NOS); and 272.0 (Pure Hypercholesterolemia). The Division has determined that the entitlement denial is not supported therefore the disputed services will be reviewed in accordance with the applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code, Section §134.600(p)(2) requires preauthorization of "outpatient surgical or ambulatory surgical services as defined in subsection (a) of the section." Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization was obtained for the outpatient hospital surgical services performed on April 27, 2006. The Division has determined that the absence of preauthorization denial is supported.
3. The Division concludes that the requestor failed to support its position that reimbursement is due. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 27, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.